Amie R. Bryant, LCSW, CAC III
Four Corners Counseling, LLC

MINOR CLIENT INFORMATION AND HISTORY

Name:_____ **Date:**_____

Mailing Address:_____ D.O.B:_____

_____ Ok to send mail? □ Yes □ No

Client Phone :_____ Email:_____
Ok to leave messages? □ Yes □ No, Text? □ Yes □ No Ok to send messages? □ Yes □ No

Mother's Name:_____Phone:_____Email:_____
Ok to contact/leave message? □ Yes □ No Ok to send messages? □ Yes □ No

Father's Name_____Phone:_____Email:_____
Ok to contact/leave message? □ Yes □ No Ok to send messages? □ Yes □ No

Who has legal custody? □ Joint □ Mother □ Father □ Other:_____

Emergency Contact Name:_____ Phone:_____

Relationship to you:_____

Are you currently a student? □ Yes □ No Grade: _____ School:_____
Are you currently employed? □ Yes □ No Employer:_____ Position:_____

How did you hear about Four Corners Counseling?_____

Please answer the following:
What brought you to counseling today? How long have these issues been causing you distress?

_____

_____

Have you had thoughts that you'd be better of dead or of hurting yourself in some way? □ Yes □ No
Have you ever attempted suicide? □ Yes □ No Have any family members ever attempted suicide? □ Yes □ No
Do you or have you engaged in self-harming behaviors (i.e. cutting)? □ Yes □ No
Have you ever been to counseling in the past? □ Yes □ No
Have you ever been hospitalized for a psychiatric illness? □ Yes □ No
Have you ever been arrested, incarcerated, and/or involved in litigation? □ Yes □ No
Please indicate, if desired, your preferred gender identity_____
Please indicate, if desired, your preferred sexual orientation_____

Please explain any positive responses above:

_____

Please list any past/current physical health problems

_____

Please list all current medications, dose, and prescribing physician

_____

Is there anything else you think I should know?_____